DPA

Colorado Health Plan Description Form
PacifiCare
HMO
Effective January 1, 2004

PacifiCare®

PART A: TYPE OF COVERAGE

1	**TYPE OF PLAN**	Health Maintenance Organization (HMO).
2	**OUT-OF-NETWORK CARE COVERED?** [1]	Only for emergency care.
3	**AREAS OF COLORADO WHERE PLAN IS AVAILABLE**	Plan is available only in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Lincoln, Logan, Morgan, Park, Teller, Washington and Weld.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

		IN-NETWORK (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4	**ANNUAL DEDUCTIBLE**	
	a) **Individual**	No deductibles
	b) **Family**	No deductibles
5	**OUT-OF-POCKET ANNUAL MAXIMUM** [2]	
	a) **Individual**	$2,500 (Per Contract Year)
	b) **Family**	$5,000 (Per Contract Year)
6	**LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE**	No Lifetime Maximum
7 a)	**COVERED PROVIDERS**	5,342 physicians and 45 hospitals in Colorado as of 8/11/2003. See provider directory for complete list.
7 b)	**WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A. ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?**	Yes
8	**ROUTINE MEDICAL OFFICE VISITS**	$30 per visit copay for PCP $50 per visit copay for Specialist
9	**PREVENTIVE CARE**	
	a) **Children's Services**	$30 per visit copay for PCP $50 per visit copay for Specialist
	b) **Adult's Services**	$30 per visit copay for PCP $50 per visit copay for Specialist
10	**MATERNITY**	
	a) **Prenatal care**	$30 per visit copay for PCP $30 per visit copay for Specialist
	b) **Delivery & inpatient well baby care**	$250 copayment per day, $1000 maximum copayment per admission.
11	**PRESCRIPTION DRUGS** Level of coverage and restrictions on prescriptions	Available as separate pharmacy plan or as an optional benefit if purchased by your employer, see benefit schedule attached (if applicable).
12	**INPATIENT HOSPITAL**	$250 copayment per day, $1000 maximum copayment per admission.
13	**OUTPATIENT/AMBULATORY SURGERY**	$125 copayment per visit.
14	**LABORATORY AND X-RAY**	No copayment (100% covered); MRI, CT, SPECT and PET Scan $100 copayment per procedure.

15	**EMERGENCY CARE** [3]	Emergency room setting inside and outside the service area: $100 copayment per visit. Urgent Care and Follow-up care to emergency services received outside the HMO service area is covered to a maximum of $400 per contract year.
16	**AMBULANCE**	$100 copayment per episode inside and outside the service area.
17	**URGENT, NON-ROUTINE, AFTER HOURS CARE**	$100 copayment in emergency room setting inside and outside the service area; otherwise $50 copayment per visit. Urgent Care and Follow-up care to emergency services received outside the HMO service area is covered to a maximum of $400 per contract year.
18	**BIOLOGICALLY-BASED MENTAL ILLNESS** [4] **CARE**	Coverage is no less extensive than the coverage provided for any other physical illness.
19	**0THER MENTAL HEALTH CARE**	
	a) Inpatient care	50% per admission; coverage for maximum of 45 full or 90 partial days per
	b) Outpatient care	$30 copayment for visits 1-5 $50 copayment thereafter.
20	**ALCOHOL & SUBSTANCE ABUSE**	
	a) Inpatient	50% of allowed charges, coverage for maximum of 45 full or 90 partial days per contract year.
	c) Outpatient	$30 copayment for visits 1-5, $50 copayment thereafter. Limited to one course of treatment per contract year, two courses of treatment during the member's lifetime.
21	**PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY**	Physical/Occupational: $30 copayment per visit, coverage for maximum of 20 sessions per acute condition. Speech Therapy: $30 copayment per visit, coverage for maximum of 20 sessions for certain acute conditions. For children born with congenital defects or birth abnormalities up to age 5, 20 visits each of physical, occupational and speech therapy per contract year; $30 copayment per visit.
22	**DURABLE MEDICAL EQUIPMENT**	Coverage for maximum of $3,000 per member per contract year, including oxygen. Coverage is limited to certain items. Orthopedic Braces and Podiatric Shoe Inserts are limited to a separate combined $500 maximum. Surgical bras meeting criteria are covered up to $500 per contract year. Prosthetic arms and legs will not be limited to the DME maximum; 80%.
23	**OXYGEN**	No copayment. Covered as durable medical equipment. (see #22)
24	**ORGAN TRANSPLANTS**	Bone marrow (for certain conditions), cornea, liver (for children) and kidney transplants, and skin grafts, are covered based on criteria. Heart, heart/lung (combined), lung, kidney/pancreas (combined), and adult liver transplants, are covered based on criteria. (see #32).
25	**HOME HEALTH CARE**	No copay (100% covered)
26	**HOSPICE CARE**	No copay (100% covered)
27	**SKILLED NURSING FACILITY CARE**	No copayment. Covered up to 30 days per contract year.
28	**DENTAL CARE**	Available as a separate dental care plan or as an optional benefit.
29	**VISION CARE**	$30 copayment per visit; one visit per 12 months.
30	**CHIROPRACTIC CARE**	Available as a separate chiropractic care plan or as an optional benefit.
31	**SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)**	Infertility treatment, 50% copayment; allergy injections, $5 copayment; well-woman exam, $30 copayment; injectables for home use, $75; cardiac rehabilitation covered to $1,000 within a 90-day period.

PART C: LIMITATIONS AND EXCLUSIONS		
32	**PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED** [5]	Not applicable; plan does not impose limitation periods for pre-existing conditions.
33	**EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No
34	**HOW DOES THE POLICY DEFINE A "PREEXISTING CONDITION"?**	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.
35	**WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?**	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.
PART D: USING THE PLAN		
36	**Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?**	Yes
37	**Is prior authorization required for surgical procedures and hospital care (except in an emergency)?**	Yes
38	**If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?**	No
39	**What is the main customer service number?**	Please call Customer Service at (800) 877-9777
40	**Whom do I write/call if I have a complaint or want to file a grievance** [6]	Write to: PacifiCare of Colorado Member Appeals Team, P.O. Box 6770, Englewood, CO 80155
41	**Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?**	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202
42	**To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.**	Policy Form #: 19B34 – State of Colorado, Large Group
43	**Does the plan have a binding arbitration clause?**	Yes

PART E: COST

44 What is the cost of this plan?

	Employee Portion	StateContribution	FullPremium
Employee only	$240.94	$156.06	$393.70
Employee + 1 dep.	$558.20	$232.52	$787.42
Employee + 2 or more dep.	$779.24	$326.46	$1,102.40

PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH

Any person interested in applying for coverage, or who is covered by or who purchased coverage under this plan, may request answers to the

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

Endnotes:

1. "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2. "Out of Pocket Maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.

3. "Emergency Care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed

4. "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressivedisorder, specific obsessive-compulsive disorder, and panic disorder.

5. Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

6. Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Selected Benefit Descriptions
Attachment R – Outpatient Prescription Drug Benefit
Colorado Health Plan Description Form Addendum

PacifiCare of Colorado

Pharmacy Plan 117R4

Benefit		Benefit Level
11	**PRESCRIPTION DRUGS**	$15 formulary generic, $40 formulary brand-name, $60 non-formulary. If brand-name is dispensed when a generic equivalent is available and listed on the drug formulary, member pays the non-formulary copayment for the brand name medication.
	Level of coverage and restrictions on prescriptions	Prepackaged units will have one applicable copayment apply per prepackaged unit. PacifiCare does require prior authorization for specific prescription drugs. A 90-day supply of maintenance medications, or a three-cycle maximum of oral contraceptives, is available through the mail-order prescription pharmacy for two applicable copayments. Prepackaged units dispensed through the mail-order prescription pharmacy will have one applicable copayment apply per two prepackaged units. For more information on the mail-order prescription drug program, or for information on drugs on our approved formulary list, call Customer Service at (800) 877-9777. *NOTE*: PacifiCare's prescription drug coverage relies on a framework provided by a drug *formulary*. Quite simply, a formulary is a list of preferred or recommended drugs that have been carefully selected by physicians and pharmacists based upon the safety and effectiveness of those drugs. You pay your applicable copayment for prescriptions filled at network pharmacies: • Formulary Generic • Formulary Brand • Formulary Brand